SCOPE OF REVIEW

This is a summary of a Quality Assurance visit with Flathead Industries conducted by Denise Smith and Kara Gehring, between May 9 – 15th, 2007 in Kalispell. The review covered the time period between August of 2005 and May 15th 2007. Consumer's who receive supported living (congregate and own apt.) services, group home, day/ facility based services, community support services as well as individuals receiving supported employment services were included in the sample reviewed. The aforementioned services are the main scope of services Flathead Industries provides, thus the sample is all encompassing. When reviewing the overall picture of services provided by Flathead Industries, happy staff and happy consumers are indicative of a well run agency. While conducting the more precise component of the review, eighteen quality assurance observation sheets (QAOS) were drafted. Eleven of the forms were in regard to noted deficiencies, 7 were written for observed commendations. Flathead Industries submitted plans of correction within the required time frames, this report will outline all QAOS forms drafted, along with plan of correction submitted by Flathead Industries. This reviewer has some suggestions that should to be added to a couple plans of correction to allow for a more appropriate approach to fix an identified deficiency.

ADMINISTRATIVE

Flathead Industries main office is in Kalispell; however, services are also provided in Columbia Falls, Whitefish and Bigfork. The agency's Board of Directors, Fiscal and Business Operations, Chief Executive Officer, and management team (group home, supported living, and day services) are located in Kalispell.

During the period of review, agency contact and communication was more than adequate. Flathead Industries was always available when questions and or concerns emerged during the period of review and continue to operate in the same fashion. The management team accomplished arranging an effective incident management system (a few suggestions will be outlined later). All incidents, aside from sensitive situations involving staff, are reviewed in the weekly committee, with appropriate subsequent action.

Flathead Industries serves 88 consumers in day services, 65 consumers in residential and 36 consumers through community supports. All group homes hold current licensure. Furthermore, above and beyond, Flathead Industries' maintains CARF accreditation good through 9/08 (QAOS #18, commendation).

Staff medication errors were a noted trend through-out the year, as a result, FI implemented a new and more efficient medication system. Medication errors in the month of April were down to 4 from the month of March in which 6 errors occurred. I felt the new medication system deserved a commendation (see QAOS #17, commendation). However, concerns did exist in terms of PRN documentation (QAOS #1), MAR documentation at the Kalispell thrift store, and the passing of medication knowledge between care providers (QAOS #7).

Upon review of the A-133 audit it was noted that Flathead Industries received an unqualified report/review, meaning financial records were in check and there were no errors noted.

Three staff files were reviewed. We did not find the need to review more because the three reviewed contained all pertinent information such as criminal background checks, more than adequate staff involved training that changes based on clientele and through policies and procedures for staff to follow. A couple of trends were noted in the staff survey, the staffing area of the report outlines this information in greater detail (see QAOS #9). Additionally, the staff surveys conducted by FI indicated staff had concerns in terms of policy notification, supervision and guidance for new hires as well as situation/ site/ consumer specific training. Staff surveys also indicated a high level of satisfaction with staff training and a general feeling of gratification within job positions.

In regard to policies and procedures the provider shared the corporation's internal grievance procedure with evidence that the procedure has been gone over with staff and residents. A concrete way for consumers and family members to be informed that choice of supported living staff is an option does not exist. Although, it was indicated through IP paperwork that an individual was able to choose staff, it was not obvious consumers were informed that choice of staff in supported living services is an afforded right. I recommend drafting a policy outlining consumer choice in regard to supported living staff and have appropriate IP team members sign receipt and acknowledgement of such policy.

There were no specific additions to the Contract through the Appendix I.

Specific Services Reviewed

GROUP HOME

Flathead Industries serves 65 consumers in residential services this includes both supported living clients as well as consumers receiving group home services. This section of the report will focus on group home services, 5 consumers in the sample receive group home services.

A. HEALTH AND SAFETY

All group homes offered a home like atmosphere and environment. Several homes were visited around meal times, the homes smelled wonderful and consumers were excited for dinner. Staff was engaged with consumers. Furthermore, of notable commendation was staff awareness regarding resident likes and dislikes. For example, consumer bedrooms were decorated with consumer input and ability to choose décor, resulting in person centered bedrooms.

All group homes visited (not including congregate SL sites) had fire extinguishers in appropriate places that recently had been serviced, as well as, evacuation procedures posted (please see supported living section for one identified concern). Additionally, in general homes were clean and in good repair, suggestions for minor repairs will be outlined below (see QAOS #14, commendation).

A sample of staff files was reviewed and evidence existed suggesting that Flathead Industries checks for correct and current driver's license of individuals who will be driving and transporting consumers. A scheduled maintenance program is in place along with procedures for repairs and completing those repairs in a timely manner. The individual completing maintenance checks trained for two years with the prior maintenance individual before assuming his role as primary maintenance man. A driver road test is completed with all staff prior to allowing any staff to drive.

While visiting with consumers a joyful positive attitude was observed. Further, consumer satisfaction surveys completed indicated a high level of satisfaction with services provided all consumers were knowledgeable regarding who to ask for assistance if needed and all felt as though they had some type of input into their lives (QAOS, #12, commendation).

In reviewing fire drill documentation concerns exist regarding a few consumers not exiting the building during a drill. On one occasion a consumer was forgotten in his room and on other occasions consumers refused to either get out of bed, the shower, etc. Consumer refusal to exit during a drill suggests consumers could benefit from training and education regarding the importance of practicing exiting a building regardless of the time of day. Furthermore, an individual's refusal to exit should be addressed in his or her individual plan (see QAOS #6).

Fire drills are conducted on a random basis, during a 24hour time period at different times in order to simulate an actual fire and the steps to take for safety, for example evacuate. Consumer education and training about how following evacuation procedures could some day save one's life in the case of an actual fire should occur (see QAOS #6).

Flathead Industries' response as to why this occurred is because consumers realize the request to exit is a drill and do not understand the importance of practicing for a possible real fire situation. The safety coordinator for Flathead Industries will review fire drill documentation and address problems individually through educational discussions or through formal training programs to be completed by 9/30/07. I would also like to suggest reviewing educational series on a regular basis (determined by IP team) with consumers whom have a hard time grasping the importance of following evacuation drill procedures.

Concern regarding monitoring hot water temperature exists at all group home sites due to a lack of evidence supporting homes regularly check hot water temperatures. At 4rth Ave. group home the lead trainer was unaware two separate hot water heaters existed. While visiting this home I asked the lead trainer if there were two hot water heaters and was told no. Once we left the home, the supervisor for all group homes informed me

that two hot water heaters existed in that particular home, and historically this has been problematic. The following day, the business manager attempted to locate a hot water thermometer for me to use. He called several sites to inquire, including 4rth Ave. group home, but to no avail. Staff was unaware that monitoring hot water temperatures on a regular basis is a health and safety requirement (QAOS #4). Additionally, this was identified as an area of concern during the prior quality assurance review. The effect of not monitoring hot water temperatures is that temps may increase above 120 degrees, which could ultimately scald an individual bathing or even just washing his or her hands.

Flathead Industries' safety coordinator and group home supervisor responded, and expressed that this had occurred due to lack of thermometers for hot water to be checked regularly. In order to resolve the aforementioned issue all group homes will have thermometers to ensure hot water is checked regularly, as of 7/2/07 this has been completed. A log should be maintained to document monthly hot water temperatures and reviewed by the safety committee.

Although each group home had bathing procedures in place for individuals with seizure disorders, safety during bathing was not addressed in the individual's plan. The possibility of this important procedure for safety could be missed by staff if not outlined in an individual's plan. This is considered an objective for a consumer with a seizure disorder because it is for that individual's safety (QAOS #2). This should be addressed through Flathead Industries' staff and case management staff coordinating individual planning.

Flathead Industries identified that the current procedure for assuring bathing procedures for an individual whom has a seizure disorder are addressed in that person's IP as ineffective. Apparently, this information is part of FI's IP check off list. Flathead industries also believe that this will no longer be an issue with the implementation of the new annual healthcare checklist, implementation to begin by 8/31/07.

While reviewing the medication system in group homes visited a health and safety concern was identified regarding as needed medication. A blanket form with an extensive list of over the counter PRN medication with a MD sign off is used. The physician does have an opportunity to check off that a particular medication cannot be used, however, there are not defined parameters listed for staff to follow. Differences in age, current prescribed medication and medical status can all contribute to an individual's ability to tolerate a certain quantity of a drug within a 24 hour period of time. Additionally, it was noted that documentation of administered PRN medication is difficult to follow resulting in staff error. For example, a prescribed over the counter as needed medication, as well as, a prescription as needed medication was to be administered in a certain order for a consumer. The order read, first give mineral oil, if not effective place 1 drop of debrox in ear every other day. This client ended up receiving debrox prior to the mineral oil and received 5 drops versus the one drop ordered. The tracking mechanism used was very confusing and set up on two different pages; it was difficult to determine how staff would decide if they would give mineral oil or debrox (ordered every other day, if mineral oil did not work --- documentation sheets did not provide an area to document if mineral oil worked or not), much room for error

existed (QAOS #1). Also, staff initials were missing on some of the medication administration sheets.

Although the above example is not life threatening, the potential for staff error is high and the possibility of overdosing an individual exists without defined consumer specific parameters and an adequate tracking mechanism in place.

The supervisor for group homes responded to this noted deficiency. The provider identified that staff on duty did not follow the directives on the medication label, staff did not follow the three point check system. The supervisor additionally stated that in order to address this issue the non-prescription medication list will be revised with a request to the doctor to note any limitations or restrictions of doses that vary from that on the label. In addition, medication sheets that track OTC medication used as needed will be reviewed to eliminate confusion, for example place related medications on one page. This response was accepted and will be implemented by 9/30/07.

As noted above a few needed minor repairs were discovered while visiting the group homes. The repairs identified did not warrant a QAOS form; however, did warrant suggestions and recommendations. At 4rth Ave. group home both consumer bathrooms were missing lids to the toilets. I asked staff if the lids had been removed for safety reasons and was told no, that when the maintenance man fixed the toilets (flushing system), in order for the toilet to flush the lid has to be off b/c the mechanism to flush pushes up further than the lid will allow ---- a very easy fix. The sprinkler head in one of the restrooms was rusted; concern exists regarding the functionality of the sprinkler. Also, a generous amount of mold was distributed behind fiberglass placed on the wall behind the toilet and along the wall. At 3rd Ave group home the linoleum in one of the bathrooms had a hole rubbed through it by the toilet and the floor in the laundry room was coming up around the drain.

Refrigerator and freezer thermometers existed in some places, not in others and worked in some and not in others. The provider has already rectified this issue. A couple of the deep freezers had quite a bit of frost and one refrigerator had moldy food. I recommend a scheduled weekly cleaning of both, as well as, defrosting the freezers on a regular basis in order to maintain health and safety standards.

Each group home site had an emergency back up system (on-call pager/ cell phone system). Medications were kept in a locked area, staff ratios were appropriate and supplies were adequate. Dangerous cleaning chemicals for the most part were locked.

B. SERVICE PLANNING AND DELIVERY

As noted above, consumer survey's indicated a high level of satisfaction with services provided by Flathead Industries. Upon interview, consumers were cheerful, knew who to ask for help when needed and could identify certain staff as individual's to ask for

assistance. All staff deserves commendation for consumer satisfaction (QAOS #12, commendation).

A couple of concerns exist in terms of individual plans having meaningful and functional objectives based on the wishes, desires and dreams of an individual, as well as, engaging in the activities of set objectives. As noted in QAOS #10 this part of the narrative will elaborate on those consumers identified on the QAOS as individual plans needing more meaningful and functional objectives that address quality of life. One consumer, has an objective to follow the recommendations of speech therapy. This appears as a non-functional objective as there is not a goal to therapy; he also has a physical therapy objective written in the same fashion. Further, his long range goals only address his desire to live more independently by working on independent skills. He has also expressed wanting to see a Cowboy's game, riding on an airplane alone and obtaining his diploma/ GED. A long range goal does not exist to aid in attaining the aforementioned desires; hence, subsequent objectives to reach this goal do not exist (QAOS, #10). Additionally, this consumer's plan does not address need for medication assistance/ or an objective addressing need.

Another consumer has two questionable objectives; add protein to diet and search out the possibility of opportunities for involvement with drama. In terms of added protein, there is no medical reason identified for this and it appears as though it is at the request of the Mother. A suggestion to aid in functionality would be a nutritional assessment and subsequent dietician recommendations for added protein if this is necessary. It seems as though searching the possibility of a drama related activity doesn't really afford an opportunity to obtain a drama related desire. A suggestion includes allowing this consumer the real opportunity to be involved with a drama related activity. The aforementioned objective does not seem to be functional (QAOS, #10). His objective to manage Amazon sales is commendable and is the right step to his long range goal of owning his own business. Upon interviewing this consumer, he very much enjoyed this activity. This objective is very innovative, functional and caters to the desires of this individual.

Further another consumer has objectives that are linked to her long range goals, there does not appear to be a long range goal and subsequent objectives to address quality of life. Her self medication program is written as completing 15 data trials versus 30 consecutive days, the later is the correct way to handle this type of medication objective. Another consumer appears to not have client- centered objectives as evidenced by lack of client participation (QAOS #10).

Considering the above information is in regard to a sample of consumers, some concern exists regarding other consumers in services having person-centered objectives. The quality of life of an individual is compromised when objectives and goals do not tend to be meaningful to the individual or functional. Although these concerns exist, IP's for the most part, did address the medical, behavioral and training needs of individuals (QAOS #10)

Flathead Industries identified that this has occurred due to a lack of a central sounding board in individual planning preparations. As of 7/2/07, there is now a central person who meets with all staff when preparing IP's, emphasizing goals that help achieve an individual's long range goal and functionality. I would also suggest training staff about the importance of addressing quality of life and client desires.

Another consumer lives in a congregate supported living environment, however, has group home funding. Although this consumer expresses satisfaction with services concern exist in terms of a rights violation. Since September of 2006 I have been aware and involved with developing a plan along with a rights restriction for this particular consumer. The case manger arranged several special IPs to address this issue. This consumer's laundry is locked in the laundry room because she tends to put dirty clothing on following a bath. Although, the rights restriction to lock up her laundry is in place the plan to reduce the need for the rights restriction had not been implemented, nor was the plan available for the staff or consumer to follow. This consumer's rights are being violated without a plan in place to reduce the need for the restriction, especially when this is part of the rights restriction. Further, the restriction would not have been approved without a plan to reduce the need for the restriction. Additionally, this individual deserves a chance to learn how to appropriately deal with her laundry so it does not have to remain locked (QAOS #3).

The provider identified that staff confusion with the program is why this occurred. The provider immediately implemented the program as a course of action to address the above issue (QAOS #3).

While conducting the review of 3rd Ave group home it was discovered that individuals did not have a concrete way of choice regarding leisure/recreational activities/ or integration into the community. It was noted that a calendar existed with activities that people did, however, there was no evidence to suggest consumers had input or choice in regard to leisure activities or community integration. The calendar shared was sparse in terms of what had happened in the past. It appears that quality of life is not considered in regard to leisure/recreational activities and/or community integration. This could lead to loss in skills, lack of motivation and possible behavioral issues related to lack of individual choice and input (QAOS #8).

Flathead industries did not agree with my observation and responded with; individuals do in fact have a concrete way of making a choice in leisure/ recreational activities/ or integration into the community through discussions and plans made with staff. Documentation included for review contained consumer meeting minutes. The provider further expressed that when planning the monthly recreation calendar, staff and consumers will review the past consumer meeting to help ensure consumer's choices are included. This information will be noted on the monthly recreation calendar. This has been implemented as of 7/2/07. It should be noted that other sites visited had consumer driven leisure opportunities.

Flathead Industries is very thorough in regard to medical and healthcare issues. Not only does the organization typically respond in a more than timely manner, prevention

tactics are also used. Medical and healthcare issues are discussed in both incident management committee meetings, and during monthly case management/ provider/ State meetings and if necessary during special IPs.

Although a couple of consumer surveys were not complete with the IP packet, consumer surveys completed by myself indicated a high level of satisfaction. Consumers identified favorite staff and no consumer identified a staff that was not favorable. An internal grievance procedure is in place.

C. STAFFING

Three staff files were reviewed. Criminal background checks were present for all files reviewed. Also, training given was comprehensive, diverse and in accordance with consumer unique needs and staff that worked with intensive individuals were enrolled in DDCPT or equivalent training. Flathead Industries recently implemented a new hiring process, where a board of individuals interview potential hires. Of notable praise, a consumer is included on the hiring board.

Upon review of staff survey completed by the provider a few trends existed. One trend indicated a high level of staff satisfaction. Another trend indicated that the provider should review the course of informing staff of new policies and policy changes, also, some new staff identified feeling overwhelmed and a lack of supervision when just beginning employment with Flathead Industries.

While conducting the staff survey a noted trend of three areas of concern existed. Every staff interviewed aside from one stated that when abuse was suspected he or she would contact supervisors first versus APS. Further, several staff had a difficult time answering what an IP is based on and two were unable to identify how to evacuate a certain building and what to do if problems occur (QAOS #9).

All staff is considered mandatory reporters of Abuse and Neglect. Mandatory reporting lawfully means reporting suspected allegations to an organization outside of the agency such as APS or law enforcement. Several issues exist, first and foremost is the well being of the individual whom abuse is suspected. Protection for that individual and the right to fair investigation is imperative. An investigation could be hindered if not acted on immediately by the proper authorities. Further, allegations may not be investigated appropriately from within the agency possibly leading to on-going abuse situations (QAOS, #9).

It is important for staff to know what IPs are based on in order to understand the importance of implementation. Further, many staff assist with writing objectives, in order to have meaningful objectives staff needs to know what to base the objectives on (QAOS, #9).

Typically consumers are trained to follow staff direction in an evacuation situation, if staff is unaware of what to do, how can residents know how be safe (QAOS, #9).

Per provider, reporting directly to APS is covered in new employee orientation but the process of more typical IR reporting that involves notifying supervisors is seen as the correct way to report incidents, no matter what kind they are. In response to the identified break down in communication Flathead Industries has issued and posted a memo regarding the correct procedure of reporting suspected abuse, including that notifying the chain of command first is not required (QAOS, #9).

Flathead Industries implemented a new individual planning process approximately two months ago (as of 7/2/07), where a central person meets with all staff who prepare for Individual plans. The meeting is intended to guide all individuals in a consistent manner in preparing for IP's and understanding what an IP is based on (QAOS, #9). I would also suggest a formal training process regarding the individual planning process for those staff that prepare individual plans.

On or before October 31, 2007, Flathead Industries will hold an all staff meeting to review the procedures for exiting respective sites and how to handle problems that may occur. The provider will continue to provide trainings on the aforementioned topic through-out the year (QAOS, #9).

The training program offered to staff of Flathead Industries is extensive, thorough, diverse, appropriate, and changes with the needs of the consumers. Clearly much time, thought and energy goes into the training program. Trainings such as MANDT, IABA and diversity training are a few to mention. Also, it is worth noting that one staff, when interviewed, mentioned that she has not worked for an agency before that offered as much training as Flathead Industries. Commendation is deserved and should be awarded to the training program coordinator (QAOS, #16, commendation).

Although during the dates of this quality assurance review no staff ratio concerns were identified, a QAOS form was written on 1/22/07 identifying a staff ratio concern at the 3rd Ave. group home. The provider identified why this occurred and rectified the problem. Further, it is recognized that gaining and maintaining staff is an industry wide difficulty. Flathead Industries has been honest about staffing issues, informing of shortages and attempts at rectifying staffing issues.

D. INCIDENT MANAGEMENT

Flathead industries incident management committee meets weekly and reviews all incidents, including internal that have occurred over the past week in all areas of service provided. The committee discusses the level of incident, if it is reportable or critical and assigns investigation if critical. The committee is well organized and the coordinator is well versed in the State Incident Management Policy. Meetings have proven to be successful prevention and identification tactics of areas of consumer need. Reporting to the appropriate authority in regard to type of incident, such as APS, has greatly improved. There are no overt issues in regard to timeliness of critical incident investigation or notification. Flathead Industries is consistent and timely in terms of

notification of incidents, as well as, investigating when necessary; this process has greatly improved since September 2006. Further, if an extension is needed, the provider requests within the specified time frame. The provider also utilizes Therap, on-line reporting program. This has proven to be successful in terms of consistent documentation of occurrences (positive and negative). Weekly meetings are also utilized as a venue to discuss current client happenings and possible need for a special IP meeting (QAOS, #15, commendation).

SUPPORTED LIVING (congregate and individual)

Out of the fourteen individuals included in the sample 4 consumers receive supported living services; two are in congregate living situations. Three congregate supported living sites were visited along with two individual apartments.

A. HEALTH AND SAFETY

Consumers interviewed with supported living services reported a high level of satisfaction, that they were able to gain rides to needed places and knew who to contact for needs. Water temperatures at congregate sites were 120 degrees and sites were clean and sanitary. Further, congregate sites offered a home-like environment with consumer – centered bedrooms (QAOS, #14, commendation). Congregate sites did not have hot water thermometers or a record of checking temperatures (QAOS, # 4) and a few minor repairs/ suggestions were noted (please see section under group home regarding this issue). Additionally, the same issue in regard to PRN medication documentation exists in congregate supported living sites as the group home (QAOS # 1).

Individual apartments either had a fire extinguisher in the apartment, or accessible in the hallway. Working smoke detectors were also noted. Two of the congregate living sites had recently serviced fire extinguishers; however, West North did not have any fire extinguishers. Additionally, this reviewer noted that during fire extinguisher service time (earlier in the year) all fire extinguishers were removed from sites and brought to the main building for servicing. The fire extinguishers sat for quite some time in the entryway to the main building, leaving sites with consumers without a fire extinguisher for that period of time. Obviously, this situation is placing consumers in risk of danger (QAOS #5).

The provider responded by explaining that the aforementioned was an oversight and that in the future, fire extinguisher servicing will be done at each site, eliminating the need to remove the extinguisher. This plan was accepted on 7/2/07, has been implemented, and next servicing will be completed in a different fashion.

Each site visited had adequate supplies with appropriate storage. An on-call emergency back-up system is in place and applicable supported living consumers were knowledgeable of how to access the on-call system. One individual had a history of safety concerns in regard to people breaking into his home; however, during the time of

this review the consumer expressed that this is no longer an issue and that staff helped resolve the problem.

B. SERVICE PLANNING AND DELIVERY

As previously mentioned, consumers expressed a high degree of satisfaction in regard to services provided. Further, Flathead Industries responds appropriately and adequately to the health and safety needs of the consumers. If a health and safety need is identified typically a special IP is held to discuss a course of action. Additionally, the provider is prompt at responding to calls from consumers in supported living services in need of assistance.

Leisure and recreational opportunities for consumers living in supported living congregate sites were exceptional. West North offered an extensive and well thought out options for activities. The manager of this site has taken the time to draw up an activity idea board full of activities that are unique and different to choose from. Brochures are available for consumers to read. Northridge also offers a great deal of unique community integrated activities that deserve commendation (QAOS, #13, commendation).

A noted trend also existed in service planning for individuals in supported living in terms of individual plans having meaningful, functional and adequate objectives based on the wishes, desires and dreams of an individual. Examples include: one consumer has an objective to attend social skills class, however, expressed she doesn't enjoy social skills class. Currently this consumer only has two supported living objectives: investigate real estate options 1 time per month and see a play or concert every other month. This individual plan does not reflect the needs associated with weekly supported living contact. Another consumer, has identified wanting to engage in leisure activities of choice; however, he is only offered to participate in established activities. A consumer expressed that he does not enjoy his cooking program; however, this is still part of his objectives (QAOS, #10).

Considering the above information is in regard to a sample of consumers, some concern exists regarding other consumers in services having person-centered objectives. The quality of life of an individual is compromised when objectives and goals do not tend to be meaningful to the individual or functional (QAOS #10).

Flathead Industries identified that this has occurred due to a lack of a central sounding board in individual planning preparations. As of 7/2/07, there is now a central person who meets with all staff when preparing IP's, emphasizing goals that help achieve an individual's long range goal and functionality. I would also suggest training staff about the importance of addressing quality of life and client desires.

Gaps in service delivery were observed with a couple of consumers in supported living. One consumer is to engage in boundary training one time per month as specified by his IP; documentation did not exist to support attendance for February or March. Another

consumer, documentation suggest gaps of more than one week (12/19-1/2, 1/23-2/12 and 2/20-3/6) exist on an objective (cleaning home) that is supposed to occur weekly, and a monthly objective (recreational) does not appear to be happening, as evidenced by documentation only for 6/06, two times in 11/06 and once on 3/07. IP objectives specify frequency of service delivery in order to assure that a particular need is being met adequately. If an objective is outlined, but not implemented accordingly, health and safety could be compromised, as well as, quality of life (QAOS, #11).

The Provider believes this is a documentation issue versus a service issue. The identified cause is a break down with newer staff and documentation requirements. The provider will continue to complete quality assurance checks and established and new employees will be reminded to review program books monthly. As of 7/2/07, according to the provider this has been completed.

C. STAFFING

Please see section on staffing under group home.

D. INCIDENT MANAGEMENT

Please see section on incident management under group home.

E. VEHICLES

Flathead industries maintain a fleet of cars and vans for supported living staff and consumers. As noted earlier, all vehicles are subject to regular maintenance checks and servicing.

WORK/DAY/ FACILITY BASED EMPLOYMENT

Flathead Industries serves approximately 88 individuals in day services. Eight out of nine consumers involved with the residential sample have day services. Flathead Industries offers an array of day service options ranging from 4 different thrift stores, a productions area, a rag barn, enclaves and a seniors program. Based on level of skill and functioning consumers are placed in appropriate setting and are given jobs to complete. While visiting each site, consumers were engaged, working and happy.

A. HEALTH AND SAFETY

The health and safety needs for consumers in day services only are primarily monitored by family members, aside from the hours the individual is with the provider. During these hours health and safety of the consumers is the responsibility of the provider. A few health and safety concerns exist in work/day services.

While reviewing the medication procedures in place at the Kalispell thrift store, I noticed inaccurate documentation on medication administration sheets. One consumer receives

two noon medications to be administered during work hours at the thrift store. One medication is calcium carbonate (Tums), the other Tegretol (anticonvulsant medication). The medication administration record for the month of March did not have either medication listed, however, staff were initialing that they were administering something, it is uncertain if staff were aware of what medications this consumer receives, how much, or how often. Another consumer's medication administration record reflected the same issue. Medication administration records are essentially a guide for certified staff to follow and a way to know when and if a medication was administered. Without the appropriate information listed on the MAR it is unclear what medication should be administered, how much, when and etc. Room for staff error is colossal, potentially resulting in harm to a consumer. Additionally, when interviewing staff at the Columbia Falls thrift store it was discovered that staff does not pass on information to the next care provider regarding OTC PRN medications that were administered during work. Clearly the potential for an overdose on PRN medication due to the next care provider being unaware that the consumer had a particular medication exists (QAOS, #7). Further, although staff express that medications were given on 5/9/07 in the production area, no medications were signed off for this date on medication administration records. Also, a consumer's medications were found, not given, and in a baggie with no directions.

Medications at production and Kalispell Thrift were stored in a locked area. Big Fork thrift had medications laying on a staff desk in an unlocked office with the door open. Several consumers work close to the office area. The manager recognized the issue and placed the medications in a locked filing cabinet. At Columbia Falls thrift, OTC medications are kept in an unlocked first aid cabinet, in an unlocked office. I would suggest locking the office.

The provider responded by identifying the above issues as an oversight by staff. Action taken to address these issues includes that a staff at the Kalispell thrift store will be assigned to oversee the medication sheets and Columbia Falls staff will be reminded of Policy. This response has been accepted provided a copy of the medication policy for thrift stores is supplied to the QIS. Per provider, this plan of action has been implemented as of 7/2/07.

All work sites visited had recently serviced fire extinguishers located in appropriate places. Further, smoke detectors were in working order. Productions has a sprinkler system through-out the building; however, only one smoke detector exists in the main area. This section of the building has several separate rooms for various activities, a suggestion includes placing smoke detectors in each separate room to aid in evacuation efficiency. There were zero concerns regarding fire evacuation drill times at production, Big Fork thrift, Columbia Falls thrift and Whitefish thrift store. The rag barn apparently conducted a drill on 1/26/07; however, a time was not recorded and Kalispell thrift in March had an evacuation time of 3 minutes, standard of care is 2 minutes. Big Fork thrift store had an egress issue, where a shoe rack was placed directly in front of an exit door. The business operations manager moved the rack to a more appropriate place and advised the manager of the situation.

Hot water temperatures were all 120 degrees or below, however, a thermometer nor log of checked temperatures existed, this has been rectified (QAOS, #4).

All day service sites were clean and sanitary with adequate supplies. Not all sites locked dangerous cleaning chemicals, I would suggest always keeping dangerous cleaning chemicals locked.

It appears that the out-lying thrift stores could benefit from an emergency back-up on-call system. The Columbia Falls thrift store manager expressed an on-call back-up system does not exist, that he has found himself in precarious situations and that it would be supportive and beneficial to have a back-up system. Also, on the day of the visit to Columbia Falls thrift store the manager was short staffed (still within contract ratio), due to a staff calling in sick.

B. SERVICE PLANNING AND DELIVERY

Individual Plans, assessments, implementation and monitoring were reviewed for 8 individuals. All IP's had work objectives that correlated with long term goals. Needed improvement in functionality and meaningful objectives as mentioned under group home and supported living apply here as well (QAOS, # 10). Also, while reviewing IP paperwork at the Big Fork thrift store it was noted that one consumer's paperwork was copied lightly to the point of making it difficult to determine what the document read. I would suggest assuring all work service sites have readable paperwork.

Leisure and recreation calendars are posted at all work sites so consumers may be apprised of upcoming events and may choose to join.

Flathead Industries assures all staff that pass medications in day services are medication certified. And, although, family for the most part monitors medical needs, day service staff are usually quick at responding to emergencies.

During the review and through-out the year emotionally-responsive care giving has been recognized, as positive interactions between consumers and staff are a norm when walking into any work situation environment. Additionally, consumer surveys indicated a high level of satisfaction with work services. If a consumer is not satisfied with work services Flathead Industries and Case management will call a special IP to determine how to provide a more satisfying job opportunity for a consumer.

C. STAFFING

Please see section on staffing under group home.

Through-out the year one staffing concern in day facility based services was brought to the attention of the CEO. This reviewer did not draft a QAOS due to the provider willingly investigating the issue and arranging meetings to address this reviewers concern. On 1/8/07, I visited Whitefish thrift store. Although staffing ratios were met,

concern existed regarding one consumer whose IP states staff will either be beside her, or assist her with ambulation through-out the store. This reviewer questioned if the staffing ratio was adequate. Several special IPs were held and this issue was resolved.

D. INCIDENT MANAGEMENT

Please see section on incident management under group home.

E. VEHICLES

Flathead industries maintain a fleet of cars and vans for staff and consumers. As noted earlier, all vehicles are subject to regular maintenance checks and servicing.

COMMUNITY SUPPORTS

Flathead Industries serves 36 consumers through community supports dollars. Five consumers were included in the sample. All receive title 19 funding. One individual who receives community supports funding only uses monies for transportation, this consumer resides with relatives. Three individuals purchase supported living services and one purchases sheltered employment. Two out of the three that purchase supported living services live with relatives.

A. HEALTH AND SAFETY

All consumer surveys indicate satisfaction with community support services provided. The five consumers reviewed seem to have needs met through utilization of community support dollars.

One consumer's apartment was visited. The apartment was clean and sanitary and access to a fire extinguisher was located directly outside the consumer's door in the hallway, he is able to identify how to evacuate and call for help. This consumer receives assistance with cooking, bills, minor cleaning tasks, and learning how to use the computer. He was very satisfied with his trainer.

No health and safety issues exist in terms of medication administration. Individuals in the sample either self-administered medication or medications were managed by relatives.

B. SERVICE PLANNING AND DELIVERY

The same concern identified in service areas above apply to community supports funded consumers as well. With some consumers goals, wishes and desires are not addressed. One consumer has identified wanting to own his own home, although a long range goal exists, objectives do not seem to correlate. One objective listed is to accompany staff into the community; it is unclear what purpose this objective holds (QAOS, #10).

Another consumer, has several medical issues that staff assists with in various ways. Although she lives at home, I would suggest adding some medical objectives to aid in her ability to attain her long range goal of maintaining supported living services while increasing independent living skills.

One consumer receiving community supports dollars does not require an individual plan; his plan of service was complete.

C. VEHICLES

Flathead industries maintain a fleet of cars and vans for staff and consumers. As noted earlier, all vehicles are subject to regular maintenance checks and servicing.

D. STAFFING

Please see section on staffing under group home.

E. INCIDENT MANAGEMENT

Please see section on incident management under group home.

TRANSPORTATION

A sample of staff files was reviewed and evidence existed suggesting that Flathead Industries checks for correct and current driver's license of individuals who will be driving and transporting consumers. A scheduled maintenance program is in place along with procedures for repairs and completing those repairs in a timely manner. The individual completing maintenance checks trained for two years with the prior maintenance individual prior to assuming his role as primary maintenance man. A drivers road test is completed with all staff prior to allowing that staff to drive.

CASE MANAGEMENT

Flathead Industries does not provide Case Management services in Region V.

CONCLUSION

One of the greatest determiners of a well operated organization is the satisfaction and happiness of both consumers and staff. All staff at all sites exhibited a positive joyful attitude, staff interviewed expressed satisfaction with employment and management staff was extremely helpful. Additionally, consumers were cheerful and engaged through-out the visit. Denise and I would like to thank you for the opportunity to review your organization.

Submitted by:

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